MIGRANT INFORMATION FORM

Client Name: _____ DOB: _____ Medicaid Number: _____

FAMILY MEMBERS THAT MIGRATE	
Name	**Relationship to Client**

Source(s) of payment for medical care if family migrates outside of Texas:
☐ N/A migrates only inside Texas

_____

_____

MIGRATING SCHEDULE	
Location	**Months at Location**
1	
2	
3	

complete the following sections for each location listed above:

LOCATION #1			
Were Client/Family Lives:	Address: City/State/Zip:		
Contact Persons:	**Name**		**Phone Number**
Medical Providers:		**Name**	**Phone Number**
	Medical		
	Dental		
	Specialist		
	Other		
School Attends:			

LOCATION #2			
Where Client/Family Lives:	Address: City/State/Zip:		
Contact Persons:	**Name**		**Phone Number**
Medical Providers:		**Name**	**Phone Number**
	Medical		
	Dental		
	Specialist		
	Other		
School Attends:			

LOCATION #3			
Where Client/Family Lives:	Address: City/State/Zip:		
Contact Persons:	**Name**		**Phone Number**
Medical Providers:		**Name**	**Phone Number**
	Medical		
	Dental		
	Specialist		
	Other		
School Attends:			

Organizations that provide assistance to family:

- ☐ I.S.D. Migrant Services/Education Service Centers
- ☐ Accelerated Services from Medicaid Managed Care Provider
- ☐ United Farm Workers
- ☐ Migrant Health Center
- ☐ National Center for Farm Worker Health
- ☐ Other(s) please specify:

_____

_____

_____

_____ _____

Case manager signature Date